

From: Yvonne Luxford
Sent: Wednesday, 24 July 2019 2:01 PM
To: Snedden, Andrew
Subject: RE: AXT Legislative Assembly - HACS Committee - Proof Hansard for Correction - 11 July 2019 - Maternity Services Inquiry.

Dear Andrew,

I have also attached the recent US research that I mentioned.

During the hearing the Chair questioned me about the level of need for accommodation for mothers and babies where the mother requires residential mental health care, and current availability here and interstate. I was incorrect in the estimation I gave the hearing, as PANDSI has recorded 8 clients over the past 12 months having required residential mental health care. Some of these have travelled interstate to St John of God hospital in Burwood, NSW to their Mother and Baby Unit <https://www.sjog.org.au/our-services/mental-health-and-therapy/perinatal-and-infant-mental-health>. Others have utilised the private unit at Calvary Private Hospital called Hyson Green which has one room set up for mothers with a cot, and a second executive suite which can have a cot added when available and necessary. The public adult mental health unit (Ward 2N) at Calvary Hospital Bruce also has 2 allocated rooms including a cot and ensuite for mothers which I had not previously known about. All of these facilities can accommodate non-mobile babies up to 6 months in age.

The Canberra Hospital does not have any accommodation for mothers with their babies. I have been informed that when being planned, the new unit included beds for mothers and babies in the Vulnerable Person Area, but this was not completed. The current usage of the Vulnerable Person Area makes it inappropriate to accommodate mothers and babies.

Currently the government run Perinatal Mental Health Consultation Service provides a consultancy service to pregnant women and mothers (up to 1 year postpartum) in residential mental health care facilities in the ACT. Their service statistics are not published as far as I can see, but the Committee may like to ask ACT Health how many women are visited in this manner annually to gain a better understanding of the demand.

Thanks again for the opportunity to speak with the Committee, and please do not hesitate to contact me with any further questions.

Kind regards,

Yvonne

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(Post and Ante Natal Depression Support and Information Inc.)

Issue BRIEF

CONTEXT

- PMADs affect 1 in 7 pregnant and postpartum women nationwide, making it the most common obstetric complication.^{4,5}
- These conditions often go undiagnosed and untreated, despite the existence of screening tools and effective treatments.⁶ In fact, only 50% of perinatal women who are diagnosed with depression receive any treatment.
- When left untreated, PMADs can become a multigenerational issue, negatively affecting the mother and child's long-term physical, emotional, and developmental health.

Dara Lee Luca, Nellie Garlow, Colleen Staatz, Caroline Margiotta, Kara Zivin

Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States

Summary. Although perinatal mood and anxiety disorders (PMADs), which include depression and anxiety disorders during pregnancy and postpartum, are common among mothers in the United States, these medical conditions often go undiagnosed and untreated.^{1,2} While PMADs have received increasing attention from policymakers and professional societies, the societal costs have not been well documented. This issue brief describes the findings from a new mathematical model that quantifies the societal costs³ of untreated PMADs from conception to age 5. The model uses the most recent data and credible estimates of maternal, child, and societal outcomes associated with untreated PMADs from peer-reviewed literature. We estimate that the total societal cost of untreated PMADs in the U.S. is \$14.2 billion for all births in 2017 when following the mother-child pair from pregnancy through five years postpartum.

RESEARCH RATIONALE AND SYNOPSIS

To our knowledge, this new mathematical model presents the most comprehensive analysis to date of the economic burden of PMADs in the United States. To construct the model, we compiled the most recent peer-reviewed literature and secondary data sources to quantify the societal costs of not treating PMADs. We collected data on the prevalence of PMADs, the outcomes associated with untreated PMADs, and the costs and baseline rates of each outcome. With this information, we created a total cost estimate for all U.S. births in 2017 when following the mother-child pair from pregnancy through five years postpartum.

Figure 2 presents our conceptual framework of how untreated PMADs influence maternal, child, and societal outcomes. As the framework shows, our model reflects the societal costs of untreated PMADs through three primary domains: (1) maternal productivity loss; (2) greater use of public sector services, including welfare and Medicaid costs; and (3) higher health care costs attributable to worse maternal and child health. These outcomes have been shown in the literature and recognized by subject matter experts to be linked to PMADs.

Key takeaways

PMADs are the **#1 complication** of pregnancy and childbirth



Nationally, PMADs affect up to **1 in 7** pregnant and postpartum women

Untreated PMADs in the U.S. are **costly** and have **multigenerational consequences**



An estimated **\$14.2 billion** for all births in 2017

Half of **perinatal women** with a diagnosis of depression do not get the treatment they need

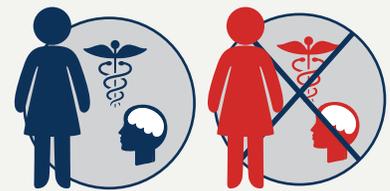


Figure 1.

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Children of mothers with PMADs have a higher risk of behavioral and developmental disorders, including attention-deficit/hyperactivity disorder (ADHD), depression, anxiety, and behavioral or conduct disorders such as oppositional defiant disorder.

Mothers with PMADs have a higher risk of suicide, cesarean deliveries, and work absenteeism and presenteeism (i.e., they may be less productive or more likely to make mistakes at work).

Conceptual model of how untreated PMADs influence maternal, child, and societal outcomes

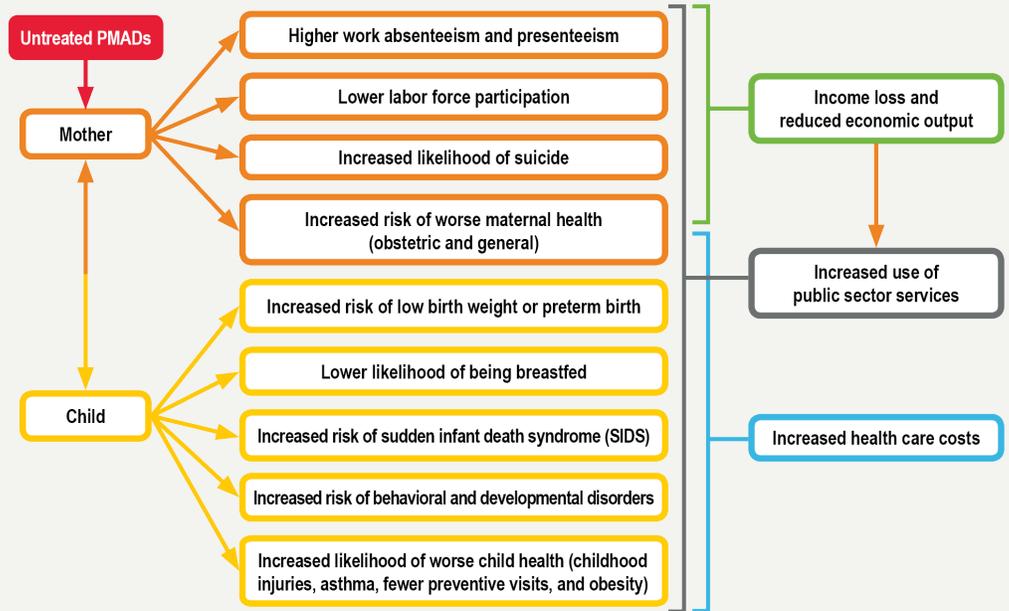


Figure 2.

KEY FINDINGS

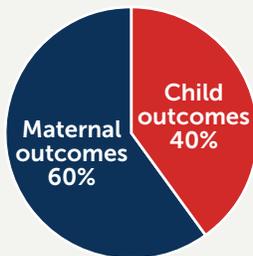
The model estimates that the societal total cost of PMADs for all births in 2017 is \$14.2 billion (Figure 1). This amounts to nearly \$32,000 in societal costs per mother with a PMAD and her child over a six-year time frame. About 60 percent of the societal costs can be attributed to maternal outcomes, with the largest costs coming from productivity losses (\$4.7 billion), maternal health expenditures (\$2.9 billion), and obstetric-specific health expenditures⁷ (\$699 million) (Figures 3 & 4). The remaining 40 percent of costs are related to child outcomes, with the largest costs coming from preterm births (\$3.3 billion), child behavioral and developmental disorders (\$1.6 billion), and child injury (\$306 million) (Figures 3 & 4). More than half of these costs (53 percent or \$7.5 billion) occur during the first year, and they are associated with pregnancy and birth complications (for example, preterm birth and other obstetric health expenditures).

- **Comparable conditions.** PMADs are not only common, they are among the most costly conditions during pregnancy and postpartum. Examining only medical costs (excluding labor force and social services costs), PMADs cost

\$17,100 per mother-child pair over a six-year time frame. Other perinatal conditions, such as postpartum hemorrhage and gestational diabetes, each cost up to \$3,300 per mother.^{8,9}

- **Conclusion.** Our model demonstrates that the total societal cost of not treating PMADs is substantial (\$14.2 billion) and that most of the costs are borne by employers and health care payers. Several medical societies (including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Psychological Association, and the Association of Women’s Health, Obstetric, and Neonatal Nurses) recommend consistently screening and providing comprehensive treatment for women diagnosed with PMADs. Efforts to decrease the prevalence of PMADs would not only positively impact the health of mothers and their children, but also lead to improvements in women’s productivity and decreased usage of social services. This would in turn benefit governments, employers, and health insurance payer groups. It is important for each of these stakeholders to support pregnant and postpartum women, including consistent screening during pregnancy up through the first year postpartum and access to effective and affordable treatment options.

2017 societal costs of PMADs



Average cost per mother-child pair: **\$32,000**

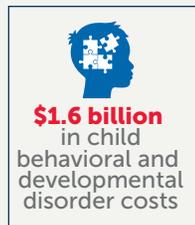
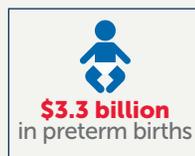
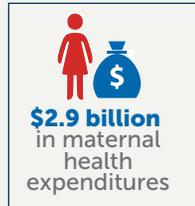
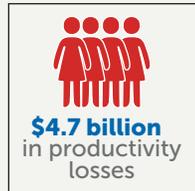
Per mother cost: **\$19,520**

Per child cost: **\$12,480**

Figure 3.

Estimates of societal costs of PMADs and impacts for births in 2017

Highest maternal and child costs



Outcome	Among 2017 births, untreated PMADs could lead to...	Cost estimate (in million \$)
Maternal		
Productivity losses	An additional 5,054 unemployed women, and an increase in absenteeism and presenteeism	\$4,652
Health expenditures*	Insurer-paid expenditures that are \$1,376 higher per mother (Individual out-of-pocket expenditures that are \$271 higher)	\$2,932
Cesarean delivery	An additional 34,168 cesarean deliveries	\$408
Peripartum stay	An additional 115,280 days spent in the hospital	\$271
Suicide	An additional 1,049 suicides	\$204
Benefit receipt	An additional 1,651 women enrolled in Medicaid, 1,570 in SNAP, 1,359 in TANF, and 1,196 in WIC	\$168
Preeclampsia	An additional 15,615 cases	\$20
Child		
Preterm birth	An additional 61,098 preterm births	\$3,306
Child behavioral and developmental disorders	An additional 24,297 children with behavioral and developmental disorders	\$1,551
Child injury	An additional 15,513 injuries per year	\$306
ED visits	An additional 85,760 ED visits per year	\$202
Asthma	An additional 15,615 children developing asthma	\$123
Breastfeeding	An additional 22,072 mothers per year not breastfeeding	\$74
Childhood obesity	An additional 22,473 children developing obesity	\$31
SIDS	An additional 516 SIDS cases	\$11
Well-child care visits	71,914 fewer well-child visits per year ¹⁰	-\$101

*Maternal health expenditures consist of all health care costs (including mental health), but do not include obstetric costs (reported separately).

Figure 4.

Mathematica Policy Research developed the cost model and this issue brief with support from the California Health Care Foundation, the Zoma Foundation, and the Perigee Fund. For more information on this work, contact Kara Zivin at KZivin@mathematica-mpr.com.

ENDNOTES

¹ Elisei, S., E. Lucarini, N. Murgia, L. Ferranti, and L. Attademo. "Perinatal Depression: A Study of Prevalence and of Risk and Protective Factors." *Psychiatria Danubina*, vol. 25, 2013, pp. S258–S262.

² Cox, E.Q., N.A. Sowa, S.E. Meltzer-Brody, and B.N. Gaynes. "The Perinatal Depression Treatment Cascade: Baby Steps Toward Improving Outcomes." *Journal of Clinical Psychiatry*, vol. 77, no. 9, 2016, pp. 1189–1200.

³ Societal costs, include direct costs, such as medical costs, and indirect costs, such as lost work time.

⁴ Gavin, N.I., B.N. Gaynes, K.N. Lohr, S. Meltzer-Brody, G. Gartlehner, and T. Swinson. "Perinatal Depression: A Systematic Review of Prevalence and Incidence." *Obstetrics & Gynecology*, vol. 106, no. 5 pt. 1, 2005, pp. 1071–1083.

⁵ US Preventive Services Task Force. "Interventions to Prevent Perinatal Depression: US Preventive Services Task Force Recommendation Statement." *JAMA*, vol. 321, no. 6, 2019 pp. 580–587.

⁶ Ko, J.Y., S.L. Farr, P.M. Dietz, and C.L.N. Robbins. "Depression and Treatment Among U.S. Pregnant and Nonpregnant Women of Reproductive Age, 2005–2009." *Journal of Women's Health*, vol. 21, no. 8, 2012, pp. 830–836.

⁷ Obstetric-specific health expenditures include cesarean delivery, peripartum stay, and preeclampsia.

⁸ UCLA Center for Health Policy Research. "Cost of Maternal Hemorrhage in California." October 2013. Available at <http://healthpolicy.ucla.edu/publications/Documents/PDF/maternalhemorrhagereport-oct2013.pdf>. Accessed February 13, 2019.

⁹ Chen, Y., W. Quick, W. Yang, Y. Zhang, A. Baldwin, J. Moran, V. Moore, N. Sahai, and T. Dall. "Cost of Gestational Diabetes Mellitus in the United States in 2007." *Population Health Management*, vol. 12, no. 3, 2009, pp. 165–172.

¹⁰ Fewer well-child visits most likely results in worse overall child health, as reflected in higher costs in the other child health categories.

Additional information on modeling methods, advisory group, and limitations

<p>Model methods</p>	<p>Our model focused on maternal and child outcomes that are linked to PMADs in the literature and recognized by subject matter experts. We initially identified 3,086 articles in our literature review and analyzed the full text of 170 articles that passed title and abstract screening. We ultimately included data from 61 papers, which we selected based on rigor and control for confounding factors.</p> <p>We used a cost of illness methodology to synthesize existing evidence and used literature and secondary data sources to inform the model's inputs. We generated model inputs that consisted of three things: (1) impact estimates, which measure the incremental effects associated with exposure to untreated PMADs (versus no exposure to untreated PMADs), (2) the prevalence of PMADs in the United States, and (3) the associated costs and baseline rates of each outcome that is affected by exposure to untreated PMADs, such as preterm birth.</p> <p>We applied the impact estimates to the baseline rate of each outcome. We then added the impact estimate (standardized to a percentage point change)—which measures the expected change in outcome because of exposure to PMADs—to the rate of the outcome among the general population so we could calculate the expected rate of the outcome among mothers with a PMAD. For example, the preterm birth impact estimate would measure the incremental risk of a preterm birth to a pregnant mother with an untreated PMAD relative to a mother without a PMAD. Adding this estimate to the baseline rate of preterm birth among the general population would yield an approximate likelihood of preterm birth for mothers with untreated PMADs.</p> <p>To calculate the aggregate excess costs of PMADs due to an outcome in a year, we multiplied the individual incremental risk of the outcome with the expected number of mothers with PMADs. We then multiplied the product by the incremental unit cost. We made additional assumptions based on the literature on the rate of recovery from untreated PMADs to extrapolate the costs to the six-year time frame. We then calculated the economic burden of untreated PMADs by summing the costs across all outcomes and years.</p>
<p>Model advisory group</p>	<p>A multistakeholder advisory group provided input on model development and messaging. The group consisted of 17 experts in a variety of fields, including maternal mental health, employment, health care (private and public), pediatric health, public policy, and statistical modeling. We met with the group four times to obtain members' feedback on the model design, inputs, results, interpretation, and value to stakeholders. Advisory Group members included: Annette Bauer (London School of Economics and Political Science), Amritha Bhat (University of Washington), Nancy Byatt (University of Massachusetts), Jamie Daw (Columbia University), Emily Dossett (University of Southern California), Marian Earls (Community Care North Carolina), Rachel Garfield (Kaiser Family Foundation), Huynh-Nhu (Mimi) Le (George Washington University), Julia Logan (Medi-Cal), Barbara Martin (Colorado State Innovation Model), Samantha Meltzer-Brody (University of North Carolina), Jennifer Moore (Institute for Medicaid Innovation), Tyann Parker Dominguez (University of Southern California), Tory Robinson (Blue Shield of California), Brynn Rubinstein (Pacific Business Group on Health), Djora Soeteman (Harvard University), and Michael Thompson (National Alliance of Healthcare Purchasers).</p>
<p>Model limitations</p>	<p>Restricted time frame. We designed this model to focus on a six-year time frame (pregnancy through five years postpartum) so that stakeholders could understand the immediate impacts of untreated PMADs. But we recognize that PMADs can have long-term effects on the mother and the child, indicating that our estimates may represent only a fraction of the lifetime costs.</p> <p>Costs of treating PMADs. This model does not explore the economic case for intervention or the costs of treating PMADs. Therefore, the model does not incorporate various treatment options nor does it differentiate between inadequate treatment and no treatment for PMADs.</p> <p>No primary data analyses. The model uses only inputs from publicly available secondary data and existing peer-reviewed literature. We did not conduct any primary data analyses for the model.</p> <p>Nonmaternal caregivers. Although we recognize that nonmaternal caregivers can also have mood and anxiety disorders, such as parental depression, we only modeled the societal burden of maternal PMADs. We also know that others in the household, such as fathers or other caregivers, can be affected by maternal PMADs, but we focused only on the mother-child pair in the model.</p> <p>Race/ethnicity subgroup analysis. Although it is important to acknowledge how PMADs affect different racial and ethnic groups, it is not possible to consistently parse out effects of other confounders, such as socioeconomic status, using available literature.</p>

